California Hospital Association

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Office of Health Care Affordability
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**Subject:** **CHA Comments on the Proposed Office of Health Care Affordability Quality and Equity Measure Set**
*(Submitted via email to Megan Brubaker)*

California's hospitals are committed to advancing health equity — a key factor in helping all Californians reach their highest potential for health — and high-quality care. Hospitals alone cannot eliminate health disparities; it will take systemic reform and broad partnership to improve the status quo. The Office of Health Care Affordability's (OHCA's) work is an important first step toward reducing disparity; its efforts to reduce health care spending must be balanced against Californians' need for expanded and equitable access to high-quality care. To ensure these multiple — and sometimes competing — objectives are achieved, OHCA must comprehensively measure trends in access, quality, and equity. Hospitals look forward to working with OHCA to develop an innovative, inclusive framework that leverages existing data collection efforts and will deepen our shared understanding of health system performance related to access and equity. Unfortunately, **the currently proposed Quality and Equity Measure Set is missing several key elements and ultimately falls short of the holistic view needed to identify and protect against unintended consequences resulting from cost containment efforts**. The California Hospital Association (CHA), on behalf of more than 400 hospitals and health systems, appreciates the opportunity to offer input and recommendations to achieve our shared goals of high-quality, affordable, and equitable health care for all Californians.

## Proposed Approach to Quality and Equity Measurement Has Merit, But Will Not Comprehensively Capture Important Trends in Access, Quality, and Equity

**Measuring Quality, Equity, and Access Is Necessary to Protect Against Unintended Consequences.** OHCA is statutorily required to ensure that its spending targets do not impair access, quality, or equity. To carry out this purpose, state law requires OHCA to develop and track a set of quality and equity measures. In concept, CHA supports OHCA's efforts to track overall health care system performance and

encourages implementation of a comprehensive and innovative approach to measuring and protecting against the unintended consequences of OHCA's cost containment efforts. However, the current proposal fails to include certain information that is vital to that understanding.

**Critical Aspects of Health Care System Performance Would Not Be Tracked Under OHCA's Proposed Approach**. The proposed approach to quality and equity measurement would provide only a partial view of health care system performance. OHCA should use existing data collected by government agencies and other organizations to fill the gaps created by the following omissions:

- **Access Measures Are Essentially Absent.** By including almost no access measures, the proposed approach to quality and equity measurement would result in a serious lack of insight into many critical measures of health system performance. The OHCA board would have no way of knowing whether:
  - Appointment and emergency department wait times are increasing
  - Patients are forced to travel farther for emergency care or labor and delivery services
  - Patients are experiencing greater difficulty obtaining a usual source of care
  - Networks of behavioral health therapists are decreasing
  - High-value — if sometimes high-cost — pharmaceuticals and other new health care technologies are growing further out of reach
  - Patients with rare diseases like hemophilia, cystic fibrosis, or muscular dystrophy are facing greater challenges obtaining the care they need to survive

  The OHCA board should direct OHCA staff to develop a supplemental plan for comprehensively measuring access to care, including for patients with chronic and rare diseases, and thereby strive to fulfill its mandate to maintain access to care while reducing spending growth. As required under state law, OHCA should use existing data collected by government agencies and other organizations to fulfill this task.
- **Quality and Equity Measures Ignore the Outcomes California's Health Care System Must Achieve.** California's health care system produces miracles every day, extending and saving lives from diseases and injuries that, one or more decades ago, would have led to certain death or impairment. And yet, **OHCA's proposed quality and equity measure set does not focus on the health care system's primary function: improving people's health.** Instead, the majority of the measures only look at preventive care processes, like whether a patient received a screening or whether just one of several specific kinds of visits occurred (e.g., well-child and prenatal visits). While the proposed measures may reflect sound **process measures**, the relative lack of true **outcome measures** — especially for entities other than hospitals — may leave OHCA with the mistaken impression that the system is performing as hoped, even while its most fundamental functions are degrading or no longer achieving their full potential. To address this deficiency, the OHCA board should ask OHCA staff to incorporate additional outcome measures into the non-hospital measures sets.

- **Creation and Diffusion of New Treatments Deserve Special Attention.** A major risk of OHCA's efforts to reduce spending is slowing the rate of innovation in health care and how quickly these innovations become available to patients. This chilling effect on innovation would cause untold avoidable disease and death. Recent analysis from the National Bureau of Economic Research underscores the reality of this risk[1], showing that a 61% reduction in Medicare payments for medical devices led to a 25% decline in new product introductions and a 75% decrease in patent filings, both indicating a slowdown in innovation. New entrants into the manufacturing market fell while outsourcing increased, leading to poorer device quality. As a result, the authors estimate that the price cuts potentially led to losses in the value of foregone innovation far exceeding the amount of Medicare dollars saved. OHCA's spending target aims to reduce total health care spending growth by almost 40% over the next five years, with potential for similar troubling effects. **Monitoring such unintended consequences is critical for OHCA to meet its mission without damaging the health of 39 million Californians.**

## Approach to Measuring Hospital Quality and Equity Is Generally Sound, But Changes Should Be Considered Over Time

**Using Existing Hospital Measures Has Significant Benefits.** OHCA has proposed to use a slate of pre-established quality and equity measures to track health care system performance. As part of that proposal, OHCA staff have recommended using the same measures as the Hospital Equity Measures Reporting Program developed by its parent department, the Department of Health Care Access and Information (HCAI), over the past several years. This approach has major advantages — most notably, compliance with the provision in state law that OHCA leverage pre-existing measures used by other regulatory bodies. Furthermore, reliance on existing measurements would minimize administrative complexity for both OHCA and hospitals, as well as reduce the degree to which hospitals are asked to adhere to disjointed sets of quality and equity performance measures that may support differing objectives. **Streamlining quality and equity performance measurement under a standard set would allow hospitals to focus their resources on meaningful improvement on a discrete set of measures.**

**Data Collection and Analysis Will Be Challenging, Requiring Additional Resources**. Collecting the required data for the Hospital Equity Measures Reporting Program will be challenging for hospitals and new for patients, especially given the sensitivity of select information. Hospitals will need to conduct comprehensive staff training to ensure a positive patient experience. In addition, HCAI has not yet made available standards for the sexual orientation and disability stratification categories; as a result, these data are not consistently collected. Since they are not clearly defined locally, statewide, or nationally, variations in definitions and collection of proposed categories will be prevalent. Hospitals may interpret

[1] Yunan Ji and Parker Rogers. "The Long-Run Impacts of Regulated Price Cuts: Evidence from Medicare." NBER Working Paper No. 33083. October 2024. https://www.nber.org/papers/w33083

categories in different ways, providing OHCA with inconsistent data across the field. **HCAI must provide clarity on these and other categories that are not currently required by federal or national agencies.** Further, these categories will require hospitals to work with their vendors to build new capabilities in their electronic health records systems to collect, analyze, and compile for a hospital's report. These and other operational issues will require all hospitals to develop new processes to ensure the patient experience is positive while balancing the caregiver burden and facilities' financial resources. While this will be difficult for all hospitals, it will be especially challenging for California's critical access, district, and rural hospitals. **When evaluating hospital spending, OHCA should recognize the significant process changes required for this reporting.**

**Detailed Stratification of Measures Is Cumbersome and May Not Lead to Insightful Conclusions.** Understanding how measures may vary by demographic variables is an important component of how OHCA's proposed interventions may impact the equity of care provided to California patients. However, detailed stratification may unintentionally create situations where data become less meaningful. The "All-Cause Unplanned 30-Day Hospital Readmission Rate, stratified by behavior health diagnosis" measure clearly illustrates this challenge. Here, the default measure has three stratification levels: Mental Health Disorder, Substance Use Disorder and Co-Occurring Disorder. Then, hospitals are required to further subset each of these categories by nine additional demographic categories, some of which have many levels (e.g., Preferred Race/Ethnicity, which itself has eight levels). For many hospitals, including small or rural hospitals, this level of stratification will result in counts that are just above the California Department of Health and Human Services De-Identification Guidelines (DDG) minimum cell count of 11 to minimize potential re-identification, but still too small to yield statistically relevant comparisons with other hospitals. **HCAI should consider reducing stratification requirements for hospital-level reports to ensure that these significant efforts produce meaningful results.**

**Misalignment of Measures for Payers, Physician Groups, and Hospitals May Lead to Data Inconsistencies.** Data reporting for hospitals has far more stringent stratification requirements compared to reporting for payers and physician organizations. Hospitals appreciate the office's adoption of existing infrastructure outlined under Assembly Bill (AB) 1204 (Chapter 751, Statutes of 2021), which defines stratification requirements. Unfortunately, the current Department of Managed Health Care (DHMC) requirements for stratification that the office proposes for payers and physician groups splits race and ethnicity in two categories, while hospitals use a combined Race/Ethnicity category, in accordance with the current Office of Management and Budget (OMB) standard. The Measures Set Document mentions that DMHC will adopt the OMB standard as soon as possible. However, starting with this misalignment will preclude the office from making meaningful comparisons across sectors. The Measure Set Document also mentions that the office will consider applying additional stratification criteria to payers as they become available. **OHCA should consider this an area of flexibility in reporting for hospitals until these sectors can be aligned and payers and physician groups use the same stratification criteria to**

**create a more cohesive view of how the health care system is performing under the proposed spending targets.**

**Despite Requirements, Measures Are Not Applicable to All Types of Hospitals.**

- **Acute Psychiatric Hospitals.** While hospitals appreciate the alignment of OHCA measures with AB 1204 measures, the structural measures that rely on guidance from the Centers for Medicare & Medicaid Services (CMS) have been delayed for acute psychiatric hospitals. It is important to note that acute psychiatric facilities were not eligible for federal Health Information Technology for Economic and Clinical Health Act (HITECH) funding, which supported the implementation of electronic health records systems for general acute care hospitals. As such, many acute psychiatric facilities will find collecting, analyzing, and stratifying data outlined in the OHCA measures to be a labor-intensive, manual process. To account for this additional challenge, OHCA should delay reporting for these facilities and align with the federal timeline.

  Additionally, acute psychiatric facilities do not and are not required to administer the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey; patients with a psychiatric diagnosis are explicitly excluded from receiving the survey. OHCA should recognize that acute psychiatric hospitals are exempt from reporting on the HCAHPS measure and therefore will not provide information on this measure.

- **Rehabilitation Hospitals and Long-Term Acute Care Hospitals.**
  Hospitals that exclusively provide extended hospital care to patients with complex medical and rehabilitative needs, such as hospitals currently federally certified as long-term acute care hospitals (LTCHs) and inpatient rehabilitation facilities (IRFs) should be exempt from the data reporting requirement. These facility types deliver post-acute care services and treat patients following their acute hospitalization for a disabling illness or injury. However, both hospital types are licensed as general acute care hospitals in California and, as such, fall under the OHCA measure set reporting requirements. However, the majority of the OHCA Quality and Equity Measures do not apply to either hospital type. OHCA should specify that these hospitals are not required to comply with the proposed OHCA Quality and Equity Measures set at this time.

**It Is Critical to Maintain Alignment With Evolving Federal Standards.** In August 2024, CMS posted the hospital inpatient prospective payment system (IPPS) final update for fiscal year 2025 along with policy, reporting, and regulation changes. For the hospital inpatient quality reporting (IQR) program, CMS adopted seven new quality measures, removed five existing measures, and modified two measures. As a result, the several measures from the Proposed OHCA Quality and Equity Measure Set are changing and/or being removed from CMS reporting requirements (detailed below). OHCA and HCAI should

maintain alignment with these changes in federal reporting requirements to minimize administrative complexity for both HCAI and hospitals and focus attention on shared improvement goals.

**Certain Measures Should Be Removed or De-Emphasized.**

- **Remove PSI-04 Death Among Surgical Inpatients with Serious Treatable Complications Core Measure for General Acute Care Hospitals.** This measure will be removed from the CMS IQR beginning with the fiscal year 2027 payment determination (July 2023–June 2025 data), to be replaced with a more broadly applicable 30-day Risk-Standardized Death Rate among Surgical Inpatients with Complications measure. HCAI should remove PSI-04 as an acute hospital core measure.
- **De-Emphasize 2024 HCAHPS Results.** The HCAHPS survey is changing in 2025, making 2024 benchmarks invalid for future years. In addition, CMS has updated its scoring methodology under the Hospital Value-Based Purchasing (VBP) Program to account for these changes. The new version of the survey will not be fully scored under the Medicare VBP program until federal fiscal year 2030 to account for new benchmarks. HCAI should account for these changes to the survey.
- **Remove Agency for Healthcare Research and Quality (AHRQ) Quality Indicator 20 (IQI 20) Pneumonia Mortality Rate Core Measure for Acute Psychiatric Hospitals.** AHRQ IQI measures are not currently calculated or required for acute psychiatric hospitals. AHRQ IQI measures are calculated using hospital inpatient discharge data for general acute care hospitals **only**, so these data are not readily available for psychiatric, children's, rehabilitation, long-term care, or cancer hospitals. The resource involved in calculating this measure — assuming it is even possible to do so — far outweighs any potential value.

## Conclusion

To successfully achieve its dual goals of improving health care affordability while promoting access, equity, and quality, OHCA must measure and report on the data that best illustrate health care system performance — and the office must allow for learning and improvement along the way. Trends related to access, quality, and equity are essential components of such a performance dashboard. While the hospital measures OHCA proposes to use are relatively comprehensive and generally feasible in terms of implementation, significant gaps in OHCA's overall quality and equity measurement plan must be addressed.

Sincerely,

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